

<IPA logo>

**NOTICE OF ACTION – TERMINATE
About Your Treatment Request**

<<Date>>

<<Member Name>>
<<Address Line 1>> <<Address Line 2>>
<<City>>, <<ST>> <<Zip>>

<<Treating Provider's Name>>
<<Address>>
<<City,>> <<State>> <<Zip>>

Identification Number: <<Member ID Number>>; Case #: <<Insert case number>>

RE: <<Service to be terminated>>

You are currently getting *[service to be terminated]*. This care is no longer approved. *[Service to be terminated]* will end on *[date]*. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

<IPA> will stop paying for this care on *[date]*.

You can get free copies of all information used to make this decision. To get this, please call <IPA> at <IPA Contact Information>.

You may appeal this decision. The enclosed “Your Rights” information letter tells you how. It also tells you how you can get free help. This can be free legal help. You can send in any information that could help your case. The “Your Rights” letter tells you the last day you can ask for an appeal.

The State Medi-Cal Managed Care “Ombudsman Office” can help you with any questions. You may call them at **1-888-452-8609**. You can also get help from your doctor or call <IPA Contact> at <IPA phone number and hours of operations>. TTY users should call **1-800-718-4347**.

This letter does not change your other Medi-Cal care.

[Medical Director's Name or Reviewer's Name]